Complaint No.

COMPLAINT FORM
KENTUCKY BOARD OF PODIATRY

Person Filing Complaint

Name _____

Address _____ City_____ State _____ Zip

Day Telephone (___) _____ Night Telephone (____) _____

Patient's Date of Birth ____ / _____ / _____

Patient Information (if different from above)

Name _____

Address _____ City_____ State _____ Zip

Relation _____

Name of Podiatrist who performed services

Name _____

Address _____ City_____ State _____ Zip

Telephone (____) _____

Names and phone numbers of persons who may provide additional information.

_____

_____

_____

_____

_____

Brief description of offense, include date, time and location

_____

_____

_____

Continue on next page

Brief description of offense (continued)

By signing this complaint form, I hereby certify that the information provided is complete and true to the best of my knowledge.

Signature _____ Date
(patient or guardian)

Send to:
Kentucky Board of Podiatry
911 Leawood Drive
Frankfort, KY 40601
Fax: 502-696-5891 or Email: BOP@ky.gov